

REGISTRATION AND TREATMENT

Date _____

Home Phone (_____) _____

Cell Phone (_____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial
Address _____ E-mail _____
City _____ State _____ Zip _____
Sex ☐ M ☐ F Age _____ Birthdate _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (_____) _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone (_____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial
Relation to Patient _____ Birthdate _____ ID#/Soc. Sec. # _____
Address (If different from patient's) _____ Phone (_____) _____
City _____ State _____ Zip _____
Person Responsible Employed By _____ Occupation _____
Business Address _____ Business Phone (_____) _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address (If different from patient's) _____ Phone (_____) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone (_____) _____
Insurance Company _____ Soc. Sec. # _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

Please Complete Above Information and Next Page